Stanford HEALTH CARE

Los Olivos Women's Medical Group

Post-partum visit

Name: _____ Pregnancies:____Children:_____Date: _____

Date of delivery: _____ Baby's name: _____ Gender: M F

Baby weight at delivery: _____ Vaginal delivery ☐ Cesarean ☐ VBAC ☐

Delivering doctor: _____ Epidural ☐ Natural ☐ Spinal ☐

Complications with pregnancy or delivery: _____

Complications with baby: _____

Problems since delivery: _____

Preferred method of birth control: None ☐ Natural ☐ Condoms ☐ Birth control pills ☐ Patch☐
Nuvaring ☐ Diaphragm ☐ Mirena IUD ☐ Paragard IUD ☐ Depoprovera ☐ Nexplanon ☐
Breast feeding: Yes ☐ No ☐ Post-partum depression: Yes ☐ No ☐

Please list any questions, symptoms, concerns or anything else that you would like to discuss:

Please check any of the following that you are **currently experiencing** or have **recently experienced**.

NONE ☐
General: Extreme ☐ Fatigue ☐ Depression ☐ Fever ☐
Weight change, how much? _____ Skin: Change in mole ☐ Rash ☐
Respiratory/ Cardiac: Shortness of breath ☐ Cough ☐ Chest pain ☐ Palpitations☐
Breast: Lump ☐ Nipple discharge ☐ Redness ☐
Gastrointestinal: Abdominal pain ☐ Blood in stools ☐ Bloating☐ Diarrhea☐
Constipation☐
Hepatitis or exposure to hepatitis ☐ Change in bowel movements ☐
Gynecologic: Heavy periods ☐ Severe pain with periods ☐
Post-menopausal bleeding ☐
PMS or Menopausal symptoms: Vaginal dryness ☐ Pain with sex ☐
Urinary: Incontinence ☐ Frequent bladder infections ☐ Blood in urine ☐
Musculoskeletal: Muscle aches ☐ Weakness ☐
Neurologic: Change in headaches☐ Numbness☐ Dizziness ☐

For Nursing and Doctors:
Height _____Weight _____B/P _____